CODE	QISMC DOMAIN 2 ENROLLEE RIGHTS
QR 01 ~~**New Element**~~	**ORGANIZATION POLICIES** **The ~~organization~~ M+CO implements written policies with respect to the enrollee rights specified in standard 2.2. [42 CFR 422.118 and 422.128] Policies are communicated to enrollees, in the enrollee statement furnished in accordance with standard 2.3, and to the organization's staff and affiliated providers, at the time of initial employment or affiliation and annually thereafter. [42 CFR 422.111], QISMC requirement 2.1.1/2.1.1.1** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE **QR 01**	Material on enrollee rights must be included in provider contracts or provider manuals and in staff handbooks or other training materials. Check with the organization to determine how enrollee rights are communicated to relevant organization staff (customer service, enrollment, utilization management and etc.) and to affiliated providers on an annual basis. Review provider manuals, policies and procedures, staff handbooks and enrollee statements.
QR 02 ~~**New Element**~~	**The ~~organization~~ M+CO monitors and promotes compliance with the policies by the organization's staff and affiliated providers. [42 CFR 422.152(f)(2)],QISMC requirement 2.1.1.2** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE **QR02**	Does the organization monitor compliance: • Through analysis of complaints or grievances? • Requests to change providers? • Enrollee satisfaction surveys? • Rapid disenrollment surveys? • Other sources of enrollee input? The M+CO must be able to provide evidence that an effective compliance plan is in place. Additionally, compliance should be addressed through education or counseling of the staff or providers or other corrective action [remedial action], and information on compliance with the policies should be considered during the recredentialing and staff evaluation process and within the QAPI program.

MOE QR 02 Cont.	The organization ensures compliance with Federal and State laws affecting the *rights of enrollees* *(Section 1A of the Guide refers to equal employment opportunity. The focus of these requirements are on the enrollee.)* [42 CFR 422.118(d) and 422.128(a)(1)(ii)(G)] Applicable Federal laws include, but are not limited to: 2.1.2 1. Title VI of the Civil Rights Act; Federal contracting ~~Medicare +Choice Organizations~~ M+COs are required under the laws administered by the Equal Employment Opportunity Commission (EEOC) to prevent discrimination in federally assisted programs. Under the rules governing grants, loans, and contracts no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. Each Federal department and agency which is empowered to extend Federal financial assistance to any program or activity by way of grant, loan, or contract other than a contract of insurance or guaranty is empowered to administer this legal requirement. Public Law 88-352, July 2, 1964; Sections 602 & 603 of the Civil Rights Act of 1964. [ ] NOTED [ ] NOT NOTED 2. Section 504 of the Rehabilitation Act of 1973; Pursuant to Section 504 of the Rehabilitation Act of 1973 which prohibits discrimination against any individual because of disability, Federal contractors are required to adhere to the prohibition against disability-based discrimination. Public Law 93-112, section 504. [ ] NOTED [ ] NOT NOTED 3. The Age Discrimination Act of 1975; [ ] NOTED [ ] NOT NOTED 4. Titles II and III of the Americans with Disabilities Act; [ ] NOTED [ ] NOT NOTED 5. Section 542 of the Public Health Service Act (pertaining to nondiscrimination against substance abusers); and [ ] NOTED [ ] NOT NOTED 6. Title 45, Part 46 of the Code of Federal Regulations, pertaining to research involving human subjects. [ ] NOTED [ ] NOT NOTED

MOE QR 02 Cont.	In general, these laws are enforced by agencies other than HCFA, and reviews conducted under this protocol will not include a detailed assessment of an organization's compliance. However, the reviewer should report any observed violations and refer any enrollee complaints to the appropriate agency for resolution. The U.S. Equal Employment Opportunity Commission (EEOC) was created by Congress and enforces Title VII of the Civil Rights Act of 1964, which prohibits discrimination based on race, color, religion, sex, or national origin. Since 1979, EEOC also has enforced Section 501 of the Rehabilitation Act of 1973, which prohibits Federal discrimination against persons with disabilities. The EEOC provides oversight and coordination of all federal regulations, practices and policies affecting equal employment opportunity. Review of these regulatory requirements is conducted by the EEOC. If their investigation shows reasonable cause to believe that an incident of discrimination occurred, they will take action that they deem necessary. On-site reviewing parties are required to refer all suspected incidents of discrimination to the HCFA central office HPPA/Performance Review Team for review. If necessary, cases may be forwarded to the headquarters office of the EEOC for possible investigation. Section 504 of the Rehabilitation Act of 1973 represents the first Federal civil rights law protecting the rights of persons with disabilities. The central requirement of this aspect of the law is program accessibility; i.e., can beneficiaries obtain Medicare services or are they otherwise prohibited from doing so due to access issues? All new facilities are required to be constructed so as to be readily accessible to and useable by persons with disabilities. Every existing facility need not be made physically accessible, but all recipients of Federal contracts must ensure that programs conducted in those facilities are made accessible. This requirement does not mandate a contract recipient to make every part of a facility accessible to and useable by persons with disabilities. If a health care provider or supplier with fewer than fifteen employees cannot structurally change the physical layout of the providing location to accommodate the needs of persons with disabilities, that provider/supplier can refer the disabled person to other providers/suppliers that are disability accessible. The Department of Health and Human Services has assigned the EEOC the enforcement provisions of this requirement. Onsite reviewing staff should first discuss their concerns with M+CO management when the reviewers(s) believe that issues affecting accessibility to services are present. History has shown that M+COs are most cooperative with concerns of this nature. Several major M+COs have incorporated in their internal review guides provider site accessibility evaluation criteria that must be met prior to contracting with a provider or groups of providers. Some have even provided assistance to providers in relocating to sites that are accessible to those with disabilities. However, if personal intervention does not result in corrective action on the part of the contractor, HCFA staff should then refer the incident to the central office HPPA/Division of Performance Review for resolution.

MOE QR 02 Cont.	The organization must include provisions relating to compliance with Federal and State laws in subcontracts with providers. Coordinate with reviewer(s) responsible for provider contract review. ~~Reviewer(s) responsible for provider contract review.~~ Assessment of compliance should be included in the organization's credentialing procedures to the extent feasible and appropriate; for example, if site visits to individual providers' offices are conducted by the organization, they should include a general assessment of physical accessibility. Compliance issues identified may be addressed through the organization's QAPI program.
QR 03	**Each enrollee has a right to be treated with respect, dignity, and consideration for enrollee privacy; [42 CFR 422.118(a)] The organization implements procedures to ensure the confidentiality of health and medical records and of other information about enrollees.42 CFR 422.118(a)],QISMC requirement 2.2.1 /2.2.1.1** **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: The organization's confidentiality procedures should apply not just to medical records, but to any information in the possession of the organization or its contractors that could disclose medical conditions or the use of specific services, such as claims information or information collected in the course of QAPI, utilization or case management, or other processes, including the enrollment process and information generated through marketing. Procedures must address both written materials and information created in other formats, such as electronic records, facsimiles, or electronic mail. The organization's procedures should protect against unauthorized or inadvertent disclosure of information to any individual, including the organization's own employees or contractors, who does not have an identifiable need for the information. In addition, procedures should ensure that no individual retains information after putting it to use for the purpose for which it was obtained.~~
MOE QR 03	Note to reviewer: The organization's confidentiality procedures should apply not just to medical records, but to any information in the possession of the organization or its contractors that could disclose medical conditions or the use of specific services, such as claims information or information collected in the course of QAPI, utilization or case management, or other processes, including the enrollment process and information generated through marketing. Procedures must address both written materials and information created in other formats, such as electronic records, facsimiles, or electronic mail. The organization's procedures should protect against unauthorized or inadvertent disclosure of information to any individual, including the organization's own employees or contractors, who does not have an identifiable need for the information. In addition, procedures should ensure that no individual retains information after putting it to use for the purpose for which it was obtained. The reviewer should coordinate this portion of the review with the individual(s) responsible for marketing, grievances/appeals and enrollment reviews. The organization's confidentiality protections must extend to minors. The organization must have policies that, consistent with State and Federal

	law, define whether and under what circumstances treatment may be furnished to a minor without parental consent and what information will be released to a parent on request. Specific issues to be addressed should include family planning, other reproductive health services, and mental health or substance abuse services. (There are some instances where minors may be Medicare beneficiaries). Review of primary care providers' own confidentiality procedures should be included as part of any organization site visits conducted under standard 3.5.1.1. Review: Written policies, credentialing/recredentialing files, marketing representative files [Have marketing representatives retained information on enrollees after the enrollment process has been completed?]
QR 04	**The right to privacy includes protection of any information that identifies a particular enrollee. Information from, or copies of, records may be released only to authorized individuals, and the organization must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Federal or State laws, court orders, or subpoenas. [42 CFR 422.118(a)],QISMC requirement ~~2.1.1.1 —~~ 2.2.1.1.1** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE **QR 04**	This standard pertains to the release of information to third parties and is not meant to impede the exchange of information among the organization, its affiliated providers, and other contractors as necessary to carry out the organization's contractual responsibilities. When certain services are "carved out," such as mental health or chiropractic, or when an enrollee is enrolled in more than one managed care organization, (such as employer group and Medicare or Medicare and Medicaid) all such Medicaid and Medicare managed care organizations in which beneficiaries are enrolled are not considered third parties for purposes of this standard. So as to ensure continuity and coordination of care, individual, identifiable personal information pertaining to such enrollees' health and health care may be released, to the extent allowed under State and Federal law, without the prior consent of the beneficiary, to any other managed care organization. **Review/Determine:** Written policies, Security of enrollee information Enrollee authorization/release form(s) in use at the M+CO
QR 05	**The ~~organization~~ M+CO implements procedures to ensure that enrollees are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. [42 CFR 422.112(a)(8)(I) and (10)(I)] [42 CFR 422.112(a)(8)(I) and (10)(I)] The M+CO ensures that it does not promote discrimination, discourage enrollment, steer specific subsets of enrollees to particular M+C plans or inhibit access to services. [42 CFR 422.100(g)],QISMC requirement 2.2.1.2**

	[ ]MET [ ]NOT MET [ ] NOTE ~~Note to reviewer: The organization must have administrative procedures in place that describe and promote nondiscriminatory practices in the delivery of health care. Participating providers must have practice policies that demonstrate that they accept for treatment any enrollee in need of the health care services they provide.~~ ~~The organization and its providers must make public declarations (e.g., through posters, member handbooks, organizational mission statements, strategic plans) of their commitment to nondiscriminatory behavior in conducting business with all enrollees. These documents should explain that this expectation applies to all personnel, clinical and non-clinical, in their dealings with each enrollee. The organization and its participating providers must abide by these written procedures.~~
MOE **QR05**	Note to reviewer: The organization must have administrative procedures in place that describe and promote nondiscriminatory practices in the delivery of health care. Participating providers must have practice policies that demonstrate that they accept for treatment any enrollee in need of the health care services they provide. The organization and its providers must make public declarations (e.g., through posters, member handbooks, organizational mission statements, strategic plans) of their commitment to nondiscriminatory behavior in conducting business with all enrollees. These documents should explain that this expectation applies to all personnel, clinical and non-clinical, in their dealings with each enrollee. The organization and its participating providers must abide by these written procedures. Does the M+CO have a program(s) in place that ensure(s) that all eligible beneficiaries have access to membership, service, choice of M+C plan and access to services? Are marketing, enrollment, member services, and provider staff given formal training or training materials to ensure that they understand HCFA policies and procedure relating to beneficiary access to membership, enrollment, and medical services while enrolled with the M+CO? If training is provided, who conducts the training and how often is the training conducted? How does the M+CO ensure that discriminatory practices towards prospective and current and enrollees are minimized? Does the organization have a mechanism to check for ongoing compliance with written non-discrimination policies? (See QISMC standard 2.2.2.1) Does the M+CO keep records of allegations of discriminatory practices towards prospective and current enrollees and does the M+CO actively pursue these allegations. If so, how? (Check complaints to see if enrollees with disabilities (physical, mental, chronic conditions, etc.) have difficulty in finding a PCP that will accept them as a patient.)

	Are participating provider manuals distributed to beneficiaries inclusive of a current listing of PCPs participating with the M+CO? If so, how often are the manuals updated?
QR 06	**Each enrollee has a right to accessible services, as specified in standard 3.1; The organization ensures that all services, both clinical and non-clinical, are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. [42 CFR 422.112(a)(10)(I)],QISMC requirement 2.2.2.1** **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: The organization must develop appropriate policies and administrative systems to address access barriers likely to be encountered by individual enrollees (whether or not part of a defined sub-population). The organization is expected to ensure that its facilities and those of a sufficient number of affiliated providers are readily accessible to the physically and mentally disabled, that translator services are available as needed for non-English speaking enrollees, and that interpreter services and other accommodations (such as teletypewriter or TTY connections for member services) are made available to the hearing-impaired.~~

MOE **QR 06**	Note to reviewer: The organization must develop appropriate policies and administrative systems to address access barriers likely to be encountered by individual enrollees (whether or not part of a defined sub-population). The organization is expected to ensure that its facilities and those of a sufficient number of affiliated providers are readily accessible to the physically and mentally disabled, that translator services are available as needed for non-English speaking enrollees, and that interpreter services and other accommodations (such as teletypewriter or TTY connections for member services) are made available to the hearing-impaired. Does the M+CO include TTY information in marketing materials/ads? (Coordinate review with reviewer responsible for marketing review). Does the M+CO have TTY equipment in its marketing and member services departments? (Coordinate review with reviewer(s) responsible for marketing and member services reviews.) Does the M+CO have policies related to handicap accessibility? Is this part of the M+CO's formal credentialing process? What translator services are available? Is the plan producing non-English language documents?

	As part of the credentialing process, are primary and secondary languages being addressed/required on the application? Is the M+CO producing documents in Braille? Review: HEDIS measure Availability of Language Interpretation Services from Access/Availability Domain.
QR 07 ~~**New Element**~~ ~~**Revised from 9/98 version of QISMC**~~	**The ~~organization~~ M+CO ~~ensures that~~ instructs enrollees have the right to access emergency health care services, consistent with the enrollee's determination of the need for such services as a prudent layperson. [42 CFR ~~422.112(a)(10)(ii)~~ 422.111 (b)(5)and 422.112(c)],QISMC requirement 2.2.2.2** **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: Emergency health care services are covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. An organization is required to ensure access to such services without requiring prior authorization instruct enrollees that they have the right to access emergency health care services without prior authorization when an enrollee's medical condition manifests acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, serious impairment to bodily functions, or serious dysfunction of any organ or body part.~~
MOE QR07	Note to reviewer: Emergency health care services are covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition. An organization is required to instruct enrollees that they have the right to access emergency health care services without prior authorization when an enrollee's medical condition manifests acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, serious impairment to bodily functions, or serious dysfunction of any organ or body part. Review the M+CO's membership card, EOC and other membership materials. M+CO membership card should explain how to access care in an emergency. Does the membership card indicate that the member may call 911 (where available) in an emergency? Does it erroneously indicate that the member must access emergency services through the plan? Do other membership materials correctly explain emergency care procedures/policies? Are emergency claims being inappropriately denied? Coordinate with the specialty reviewer(s) responsible for the review of denied claims and grievances/appeals.

QR08	**Each enrollee has a right to choose providers from among those affiliated with the organization; [42 CFR 422.112(a)],QISMC requirement 2.2.3** **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: Each enrollee must have a right to select his or her primary care provider, as provided under standard 2.2.3.1, and to change this selection at any time. Similarly, in the case of mental health and substance abuse services, although an enrollee's primary provider of these services may initially be assigned through, for example, a triage system, the enrollee must have a right to select a different primary provider.~~
MOE QR 08	Note to reviewer: Each enrollee must have a right to select his or her primary care provider, as provided under standard 2.2.3.1, and to change this selection at any time. Similarly, in the case of mental health and substance abuse services, although an enrollee's primary provider of these services may initially be assigned through, for example, a triage system, the enrollee must have a right to select a different primary provider. Do written organization policies support this right? Does the EOC? Does the plan make information on specific providers available to enrollees to assist them in making informed decisions on treatment? In order to facilitate enrollee selection of providers, the organization must make available to enrollees, on request, information including education, board certification, and recertification status; names of M+CO plan contracting hospitals where physicians have admitting privileges; years of practice as a physician and as a specialist, if so identified; experience with performing certain medical or surgical procedures; consumer satisfaction measures; and clinical quality performance measures. Practice-level information on clinical quality and consumer satisfaction measures should be provided to enrollees, if available in addition to M+CO level data. Review policies and procedure to determine if M+CO has developed a system to make this information available to beneficiaries.
QR09	**The M+CO ensures that each enrollee may select his or her primary care provider from among those accepting new Medicare enrollees. [42 CFR 422.112(a)(2)],QISMC requirement 2.2.3.1** **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: New enrollees must be informed of the primary care providers available and the procedures for selecting a provider. An organization that requires use of the primary care provider to obtain other services may assign a provider for enrollees who have failed to make a selection within a reasonable time period specified in the organization's procedures. In the event of assignment, the enrollee must be notified of the assignment and of the procedures for changing the designated provider.~~

	~~In the event a primary care provider ceases to be affiliated with the organization, the organization must promptly assist enrollees in obtaining a new primary care provider. The organization's procedures must provide for notice to affected enrollees within 15 working days of the M+CO's receipt of or issuance of a notice of provider termination. The notice to an affected member must include information on how to select a new primary care provider. In the event an affiliation is terminated because a specific provider has left a group or facility that continues to contract with the organization, the enrollee may be offered an opportunity to select from among other providers at the site who are continuing to accept new patients. However, the enrollee must also be notified of the right to select another site, where one is available.~~
MOE **QR 09**	Note to reviewer: New enrollees must be informed of the primary care providers available and the procedures for selecting a provider. An organization that requires use of the primary care provider to obtain other services may assign a provider for enrollees who have failed to make a selection within a reasonable time period specified in the organization's procedures. In the event of assignment, the enrollee must be notified of the assignment and of the procedures for changing the designated provider. Does the organization indicate which PCPs are accepting new Medicare enrollees and any other restrictions? How frequently are provider directories reprinted/updated? Review a copy of the letter the M+CO uses to notify Medicare enrollees of termination of their PCP's affiliation with the plan. Is it clear and does it meet HCFA Marketing Guideline requirements? Has it been reviewed/approved by the HCFA RO? Do plan written procedures require the notice to be sent as soon as the plan becomes aware of the provider termination? **Review:** HEDIS measure Practitioner Turnover measure (in context of marketplace) as part of review of network.
QR 10	**Each enrollee has a right to participate in decision-making regarding his or her health care; [42 CFR 422.112(a)(8)(iii)] The organization provides for the enrollee's representative to facilitate care or treatment decisions when the enrollee is unable to do so. [42 CFR 422.128(a) and (b)] The organization provides for enrollee or representative involvement in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment, and complies with requirements of Federal and State law with respect to advance directives. [42 CFR 422.128 and 422.206(b) ~~and (c)~~],QISMC requirement ~~2.2.41~~ 2..2.2.1/2.2.4.1/2.2.4.2** **[ ] MET [ ] NOT MET [ ]NOTE** ~~Note to reviewer: The organization's policies must promote enrollees' understanding of their conditions or problems and facilitate development of mutually agreed upon treatment goals. While participation in treatment planning is important for all enrollees, special emphasis should be placed on involvement of enrollees and/or their families in development of plans of care for enrollees with mental health or substance problems, with chronic diseases, or at the end of life. Written policies and procedures address the care and treatment of enrollees who are unable to exercise rational judgment or give informed consent. State law will generally govern who may act as an enrollee's representative.~~

MOE **QR 10**	Note to reviewer: The organization's policies must promote enrollees' understanding of their conditions or problems and facilitate development of mutually agreed upon treatment goals. While participation in treatment planning is important for all enrollees, special emphasis should be placed on involvement of enrollees and/or their families in development of plans of care for enrollees with mental health or substance problems, with chronic diseases, or at the end of life. Written policies and procedures address the care and treatment of enrollees who are unable to exercise rational judgment or give informed consent. State law will generally govern who may act as an enrollee's representative. With respect to advance directives, the organization must meet all five factors (below) in order to meet this requirement: (1) inform all Medicare enrollees at the time of enrollment of their right (under state law, whether statutory or recognized by the courts of the state) to accept or refuse treatment and to execute an advance directive, such as living wills or durable powers of attorney, and of the organization's written policies on implementation of that right (including a clear and precise statement of limitation, if the organization cannot implement an advance directive as a matter of conscience); (2) document in the enrollee's medical records whether or not an individual has executed an advance directive; (3) not make treatment conditional or otherwise discriminate on the basis of whether an individual has executed an advance directive; (4) comply with state law, whether statutory or recognized by the courts of the state, on advance directives; and (5) provide (individually or with others) for education of staff and the community on advance directives. **Note:** Requirements related to advance directives are not limited to directives concerning care at the end of life. The organization should also ensure compliance with other forms of patient instructions, such as psychiatric advance directives. Absent evidence to the contrary, assume items (3) and (4) (above) are met. Check marketing materials to ensure enrollees are informed at the time of enrollment of their right to complete advance directives. Also, check the organization's Provider Manual given to PCPs to ensure that policies are in place to document the enrollee's medical record, if the enrollee completes an advance directive. If the organization has requested a "conscience protection" from HCFA, ensure that prospective enrollees and current enrollees have been properly informed per 422.206(b) and (c).
QR 11 ~~**Revised**~~	**Each enrollee has a right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified in standard 2.3; [42 CFR 422.206(a)] Health care professionals must provide**

~~from 9/98 version of QISMC~~	**information regarding treatment options in a language that the enrollee understands.** ~~**Prospective and current enrollees are provided requisite notice when an M+CO objects to providing counseling or referral services based on moral or religious grounds. Prospective enrollees must be notified before or during the enrollment process, if the M+CO has an existing policy covered by the "conscience protection" provision in 42 CFR 422.206(b). Current enrollees must be notified within 90 days of the M+CO actually adopting a new policy covered by the "conscience protection" provision in**~~ **42 CFR 422.206(b)(1). [42 CFR 422.206 (a) and (b)],QISMC requirement 2.2.5** **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: Contracts with providers may not limit a provider's ability to counsel or advise a Medicare enrollee on treatment options that may be appropriate for the enrollee's condition or disease, whether or not the options are covered by the organization. Enrollees have a right to a clear explanation of: their condition; any proposed treatments or procedures and alternatives; the benefits, drawbacks, and likelihood of success of each option; and the possible consequences of refusal or non-compliance with a recommended course of care.~~
MOE QR 11	Note to reviewer: Contracts with providers may not limit a provider's ability to counsel or advise a Medicare enrollee on treatment options that may be appropriate for the enrollee's condition or disease, whether or not the options are covered by the organization. Enrollees have a right to a clear explanation of: their condition; any proposed treatments or procedures and alternatives; the benefits, drawbacks, and likelihood of success of each option; and the possible consequences of refusal or non-compliance with a recommended course of care. Does the M+CO provide sufficient notice to prospective and current enrollees as well as to HCFA, when services cannot be provided by the M+CO based on religious or moral grounds? An M+CO must provide conscience protection policies to HCFA with its application for a Medicare contract, or within 10 days of submitting its ACR proposal, as appropriate. For policy changes, the M+CO has 90 days after adopting a new policy covered by 42 CFR 422.206(b)~~(1)~~ to communicate that new policy to current members. **Review/Determine:** Examine marketing materials to ensure that proper notice is included as part of the M+CO's marketing materials. Interview enrollment and member services staff for their understanding of this requirement. Ensure that materials are made available to current members and are provided annually in the M+CO's EOC. Confirm with CO plan manager and financial staff that proper documentation was submitted to HCFA, including the ACRP. Coordinate with reviewer(s) responsible for provider contract review and review of complaints/appeals/grievances.
QR 12	**Each enrollee has a right to have access to his or her medical records in accordance with applicable Federal and State laws. [42 CFR**

	422.118(ed)],QISMC requirement 2.2.6 **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: The organization must have procedures through which an enrollee can obtain timely access to all medical records and health information maintained by the organization, including records maintained by subcontracting providers from whom the enrollee has received services in accordance with applicable Federal and State laws. (Note: M+CO policies instructing enrollees to contact their provider directly for access to health records are permissible for non-staff model M+COs and where subcontracting arrangements are present. However, the M+CO must assist the beneficiary in all cases where medical records are requested and where difficulty in obtaining those records is experienced.)~~
MOE **QR 12**	Note to reviewer: The organization must have procedures through which an enrollee can obtain timely access to all medical records and health information maintained by the organization, including records maintained by subcontracting providers from whom the enrollee has received services in accordance with applicable Federal and State laws. (Note: M+CO policies instructing enrollees to contact their provider directly for access to health records are permissible for non-staff model M+COs and where subcontracting arrangements are present. However, the M+CO must assist the beneficiary in all cases where medical records are requested and where difficulty in obtaining those records is experienced.) Check the organization's written policies, Provider Manual(s), provider contracts. Coordinate review with reviewer(s) responsible for review of complaints/appeals/grievances, member services and administration and management (for provider contracts). Note to reviewer: While some medical records are maintained by the M+CO, most non-staff model M+COs require their subcontracted providers to maintain the medical record.
QR 13	**Each enrollee receives, at the time of enrollment and at least annually thereafter, a written statement including information on:** **2.3.1.1 Enrollee rights;** **2.3.1.2 Enrollee responsibilities;** **2.3.1.3 The names and locations of network providers, including information on which providers are accepting new Medicare patients and any restrictions on enrollees' ability to select from among network providers; (See 2.2.3.1)** **2.3.1.4 Amount, duration and scope of all benefits and services included and excluded as a condition of enrollment, including a description of how the organization evaluates new technology for inclusion as a covered benefit;** **2.3.1.5 Procedures for obtaining services, including authorization requirements, any special procedures for obtaining mental health and substance abuse services, procedures for obtaining out-of-area coverage and, in the case of enrollees eligible for a point-of-service benefit, procedures for obtaining services through the benefit, including special conditions or charges that may apply;** **2.3.1.7 Provisions for after-hours and emergency coverage;**

	2.3.1.8 Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider; **2.3.1.9 Charges to enrollees, if applicable;** **2.3.1.10 Procedures established under standard 2.4 for resolving enrollee issues, including complaints or grievances and issues relating to authorization of, coverage of, or payment for services;** **2.3.1.11 Procedures for changing primary care providers;** **2.3.1.12 Procedures for recommending changes in policies or services;** **2.3.1.13 Information on service area; and** **2.3.1.14 Notice of the right to obtain the following information:** **2.3.1.14.1 In addition to the information in standards 2.3.1.1 through 2.3.1.13, the following information is available, upon request:** **2.3.1.14.2 The procedures the organization uses to control utilization of services and expenditures.** **2.3.1.14.3 The number of grievances and appeals and their disposition in the aggregate, in a manner and form specified by HCFA.** **2.3.1.14.4 A summary description of the method of compensation for physicians.** **2.3.1.14.5 The financial condition of the organization, including the most recently audited information regarding its condition.** **[42 CFR 422.111(b) and (c)],QISMC requirement 2.3.1** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QR 13	Written organization materials given to enrollees at the time of enrollment and annually thereafter (during the annual notification process) must contain information in 2.3.1.1 - 2.3.1.14 and must also indicate how an enrollee may obtain information in 2.3.1.14.1 - 2.3.1.14.5. Coordinate with reviewer responsible for marketing review.
QR 14	**The organization notifies enrollees affected by termination of/or changes in benefits, services, service sites, or affiliated providers. To the extent practical, enrollees are informed of such terminations or changes prior to their effective date. [42 CFR 422.111(e)],QISMC requirement 2.3.2** **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: Notice of changes in benefits or in the organization's rules for obtaining benefits must be provided to affected beneficiaries at least 30 days before the change takes effect. Reductions in benefits or increases in premiums can only occur at the beginning of the contract period - January 1. Notice of a termination of a primary care provider must be provided within 15 working days of M+CO receipt of or issuance of the notice of termination.~~
MOE QR 14	Note to reviewer: Notice of changes in benefits or in the organization's rules for obtaining benefits must be provided to affected beneficiaries at least 30 days before the change takes effect. Reductions in benefits or increases in premiums can only occur at the beginning of the contract period - January 1. ~~Notice of a termination of a primary care provider must be provided within 15 working days of M+CO receipt of or issuance of the notice of termination.~~ The organization must make a good faith effort to provide written notice of a termination of a contracted provider

	within 30 days of reciept or issuance of a notice of termination [42 CFR 111 (e)]. Coordinate with reviewer(s) responsible for member services appeals/grievances and marketing review.
QR 15	**Enrollee information is readable and easily understood; [42 CFR 422.111(a)(2)],QISMC requirement 2.3.3/2.3.3.1** **[ ] MET [ ] NOT MET [ ] NOTE** ~~Note to reviewer: Generally materials should be understandable to enrollees at a fifth-grade reading level. The fifth-grade reading level is not a requirement, but is rather a guideline.~~
MOE QR15	Coordinate with reviewer(s) responsible for marketing review. Note to reviewer: Generally materials should be understandable to enrollees at a fifth-grade reading level. The fifth-grade reading level is not a requirement, but is rather a guideline.
QR 16	**Enrollee information is available in the language(s) of the major population groups served and, as needed, in alternative formats for the visually impaired. OPL 98-72,QISMC requirement 2.3.3.2** ~~Note to reviewer: The organization should have a procedure for ascertaining the primary language of enrollees and for making information materials available in any language that is the primary language of the geographic area (contracted service area). As a rule of thumb, where more than 10 percent of the enrollees eligible for M+CO enrollment have a primary language other than English, consideration should be given to providing information materials in those other languages. Basic enrollee information, except for the provider listing required under standard 2.3.1.3, must also be made available to the visually impaired in large print and Braille formats or through recorded cassettes.~~ **[ ] YES [ ] NO [ ] NOTE**
MOE QR 16	Note to reviewer: The organization should have a procedure for ascertaining the primary language of enrollees and for making information materials available in any language that is the primary language of the geographic area (contracted service area). As a rule of thumb, where more than 10 percent of the enrollees eligible for M+CO enrollment have a primary language other than English, consideration should be given to providing information materials in those other languages. Basic enrollee information, except for the provider listing required under standard 2.3.1.3, must also be made available to the visually impaired in large print and Braille formats or through recorded cassettes. Coordinate with reviewer(s) responsible for marketing and member services reviews. Does the M+CO have a procedure for identifying primary

	languages used in its service area? Are materials prepared in non-English languages, when the 10 percent threshold is reached? Are materials available in large print and/or Braille and/or through recorded cassettes for the visually impaired? **Review:** HEDIS measure Availability of Language Interpretation Services from Access/Availability Domain.

QR 17	**The organization evaluates the effectiveness of its communications with enrollees. OPL 98-72, QISMC requirement 2.3.4** **[ ] YES [ ] NO [ ] NOTE** ~~Note to reviewer: The organization's enrollee surveys could include a focus on the extent to which Medicare enrollees understand key concepts of health plan enrollment and are able to use information materials. Alternatively, materials could be tested with focus groups, enrollee advisory committees, or other groups of Medicare enrollees. Other means are permissible.~~
MOE QR 17	Note to reviewer: The organization's enrollee surveys could include a focus on the extent to which Medicare enrollees understand key concepts of health plan enrollment and are able to use information materials. Alternatively, materials could be tested with focus groups, enrollee advisory committees, or other groups of Medicare enrollees. Other means are permissible. Coordinate with reviewer(s) responsible for marketing and member services reviews.
QR 18	**The ~~organization~~ M+CO has a system for resolving issues raised by enrollees, including: complaints or grievances; issues relating to authorization of, coverage of, or payment for services; and issues relating to discontinuation of a service. [NOTE: references to an enrollee in these standards include reference to an enrollee's representative.] [42 CFR 422.562(a)(1)], QISMC requirement 2.4** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QR 18	Coordinate with reviewer(s) responsible for member services and appeals/grievances reviews.
QR 19	**The ~~organization~~ M+CO documents each issue raised by an enrollee. OPL 98-72, QISMC requirement 2.4.1.1** **[ ] YES [ ] NO [ ] NOTE** ~~Note to reviewer: There may be instances in which an enrollee expresses a concern orally to staff of the organization or an affiliated provider, and the issue is resolved to the enrollee's satisfaction immediately and informally. Nevertheless, the issue and its resolution should be recorded,~~

	~~through a complaint log or other means, so that information on volume and nature of enrollee issues is available in the QAPI process and for other management functions.~~

MOE QR 19	Note to reviewer: There may be instances in which an enrollee expresses a concern orally to staff of the organization or an affiliated provider, and the issue is resolved to the enrollee's satisfaction immediately and informally. Nevertheless, the issue and its resolution should be recorded, through a complaint log or other means, so that information on volume and nature of enrollee issues is available in the QAPI process and for other management functions. Have the organization provide documentation that it captures enrollee concerns, including those expressed orally, and that through a consolidated compliant log or some other means tracks enrollee concerns in a unified manner that ensures the organization is responsive to enrollee concerns.
QR 20	**The ~~organization~~ M+CO acknowledges receipt of the issue and explains to the enrollee the process to be followed in resolving his or her issue; OPL 98-72, QISMC requirement 2.4.1.3** [ ] YES [ ] NO [ ] NOTE ~~Note to reviewer: In the case of grievances, acknowledgment of receipt and explanation of the process may be made orally; however, grievances relating to quality of care issues should be acknowledged in writing, and the acknowledgment should specifically describe the quality issue raised by the enrollee. Quality issues include concerns expressed related to the adequacy or appropriateness of care provided or concerns expressed about the professionalism or demeanor of providers.~~
MOE QR 20	Note to reviewer: In the case of grievances, acknowledgment of receipt and explanation of the process may be made orally; however, grievances relating to quality of care issues should be acknowledged in writing, and the acknowledgment should specifically describe the quality issue raised by the enrollee. Quality issues include concerns expressed related to the adequacy or appropriateness of care provided or concerns expressed about the professionalism or demeanor of providers. Coordinate with reviewer(s) responsible for member services and appeals/grievances reviews.
QR 21	**The ~~organization~~ M+CO informs the enrollee of any applicable mechanism for resolving the issue external to the organization's own processes. OPL 98-72, QISMC requirement 2.4.1.5**

	[ ] YES [ ] NO [ ] NOTE ~~Note to reviewer: The enrollee must be notified of alternative routes for resolution of his or her issue. An enrollee has a right to submit a quality of care complaint for investigation by the PRO, instead of pursuing it through the organization's grievance process.~~ ~~Coordinate with reviewer(s) responsible for member services and appeals/grievances reviews.~~
MOE QR 21	Note to reviewer: The enrollee must be notified of alternative routes for resolution of his or her issue. An enrollee has a right to submit a quality of care complaint for investigation by the PRO, instead of pursuing it through the organization's grievance process. Coordinate with reviewer(s) responsible for member services and appeals/grievances reviews.

QR 22	**The ~~organization~~ M+CO implements a procedure, with clearly explained steps and time limits for each step, for the resolution of a complaint or grievance. The grievance is transmitted in a timely manner to staff who have authority to take corrective action. A grievance relating to quality of care is transmitted to appropriately qualified personnel within the health plan.** **The organization investigates the grievance and notifies the concerned parties of the results of the investigation and the proposed resolution. [42 CFR 422.564(a)(2)], QISMC requirement 2.4.2/2.4.2.1/2.4.2.2** **~~(Note: Physician peer review findings are confidential and not releasable to be enrollee)~~** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QR 22	(Note: Physician peer review findings are confidential and not releasable to the enrollee) Check to ensure that the resolution directly addresses the issue raised in the grievance, and the proposed solution is appropriate to the seriousness of the complaint. Coordinate with reviewer(s) responsible for member services and appeals/grievances reviews.
QR 23 ~~New Element~~	**The ~~organization~~ M+CO provides an opportunity for reconsideration of the proposed resolution. OPL 98-72, QISMC requirement 2.4.2.3** **[ ] YES [ ] NO [ ] NOTE** ~~Note to reviewer: When the enrollee is not satisfied with the proposed resolution of a grievance, there must be an opportunity for further consideration by an individual or individuals other than the individual who initially reviewed the grievance.~~
MOE QR 23	Note to reviewer: When the enrollee is not satisfied with the proposed resolution of a grievance, there must be an opportunity for further consideration by an individual or individuals other than the individual who initially reviewed the grievance. Coordinate with reviewer(s) responsible for member services and appeals/grievances reviews. Does the notice to the enrollee transmitting the

	organization's grievance decision/resolution indicate that further steps are available, if the enrollee is not satisfied with the proposed decision/resolution?
QR 24 ~~**New Element**~~	**The ~~organization~~ M+CO tracks each grievance until its final resolution. OPL 98-72, QISMC requirement 2.4.2.4** **[ ] YES [ ] NO [ ] NOTE** ~~Note to reviewer: The organization must have a system for monitoring its progress in reviewing and resolving each grievance, to assure that each step is completed within the time frame specified in the organization's grievance procedures.~~
MOE QR 24	Note to reviewer: The organization must have a system for monitoring its progress in reviewing and resolving each grievance, to assure that each step is completed within the time frame specified in the organization's grievance procedures.
QR 25 ~~**New Element**~~	**The ~~organization~~ M+CO has an expedited grievance process for issues requiring immediate resolution. OPL 98-72, QISMC requirement 2.4.2.5** ~~**Note to reviewer: This would be true, for example, when an enrollee reports that he or she is unable to obtain a timely appointment from a primary care provider for a problem in need of immediate attention.**~~ **[ ] YES [ ] NO [ ] NOTE**
MOE QR 25	Note to reviewer: This would be true, for example, when an enrollee reports that he or she is unable to obtain a timely appointment from a primary care provider for a problem in need of immediate attention. Coordinate with reviewer responsible for appeals/grievances review.
QR 26 ~~**New Element**~~	**Monitoring of Issue Resolution Processes. The organization maintains, aggregates and analyzes information on the nature of issues raised by enrollees and on their resolution. [42 CFR 422.111(c)(3) and OPL 99.081 dated 2/10/99], QISMC requirement 2.4.4/2.4.4.1 The information is used to develop activities under the organization's QAPI program, both to improve the issue resolution process itself, and to make improvements that address other system issues raised in the issue resolution process.** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QR 26	See standards 1.3.5.3 and 2.4.1.1.
QR 27	**Information related to coverage and payment issues is maintained for at least six years following final resolution of the issue, and is made available to the enrollee on request. 42 CFR 422.502(d)~~(1)(I iii)~~, QISMC requirement 2.4.4.2**

	[ ] YES [ ] NO [ ] NOTE
MOE QR 27	Coordinate with reviewer(s) responsible for member services and appeals/grievances. The M+CO must retain records and commit resources sufficient to allow HCFA (and current or former members) to resolve disputes and concerns related to services performed and determinations of amounts payable or paid under the M+C contract.